CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF DENTISTRY AND DENTAL HYGIENE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

APPLICATION FOR UNRESTRICTED PERMIT
Deep Sedation, Conscious Sedation and General Anesthesia

INSTRUCTION SHEET

What Does an Unrestricted Permit Allow?

An Unrestricted Permit allows you to induce both ***conscious sedation*** – either by parenteral, enteral, or rectal routes or by nitrous oxide inhalation – and ***deep sedation***. You are allowed to administer general anesthesia.

Before applying for a permit for sedation or anesthesia, it is imperative for you to thoroughly review Section 7.0 of the Rules and Regulations of the Delaware Board of Dentistry and Dental Hygiene. The Board's rules define conscious sedation (both via nitrous oxide inhalation and by the parenteral route), deep intravenous sedation and general anesthesia using definitions adapted from the American Dental Association (ADA). The educational requirements for deep sedation and general anesthesia are much more stringent than for conscious sedation. This distinction is important both from the standpoint of this permit application and from the standpoint of clinical practice.

Inspection Requirement

The Anesthesia Advisory Committee (AAC) must complete a satisfactory inspection of your office before a permit is issued. The AAC reviews applications and performs inspections under the Board's direction.

- Submit a separate application for ***each location*** where you will administer sedation or anesthesia.
- Submit your application for a permit only when the location is ***ready*** for AAC inspection.

Requirements for Permit Applications

It is your responsibility to arrange for the Board to receive all documents listed below. If clarification is needed, the Board may request more information or documents.

☐ Submit completed, signed and notarized *Application for Unrestricted Permit*.

☐ Enclose the non-refundable processing fee by check or money order made payable to the "State of Delaware."

☐ Submit documentation that you meet at least one of the following qualifications:

- You have two years of advanced training in Anesthesiology and related academic subjects (or its equivalent) beyond the undergraduate dental school level in a training program as described in Part II of the Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry.
- You are certified as a diplomat of the American Board of Oral and Maxillofacial Surgeons.
- You have satisfactorily completed a residency in Oral and Maxillofacial Surgery at an institution approved by the ADA Council of Dental Education.
- You are a fellow of the American Dental Society of Anesthesiology.
- You are employed by or work with a physician (M.D. or D.O.) who is a member of the anesthesiology staff of an accredited hospital. If you are seeking a permit based on this qualification, arrange for the Board to receive a letter *directly* from the physician stating that you are an employee or co-worker and that he/she is on the anesthesiology staff of a hospital.
    - The physician must remain on the dental facility's premises until a patient given a general anesthetic or deep sedation regains consciousness.

☐ Enclose a copy of your current advanced cardiac life support (ACLS) certification card.

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.

- The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 Del. C. §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 Del. C. §2216) and for other lawful purposes.

If approved, your Unrestricted Permit will be mailed to the address on your Dentist license. You may change the mailing address for your Dentist license and permit(s) online at Update Contact Information.

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IDENTIFYING AND CONTACT INFORMATION

1. Name: _____ _____ _____ _____
   Last/Family Name | First | Middle | Maiden

2. Other Name(s) Used: _____ _____ _____

3. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

4. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ If yes, enter your SSN:_____
   If no, you must file a *Request for Exemption from Social Security Number Requirement*.

5. Delaware Dental License Number: **G1 -** _____ **An active Delaware Dentist license is required. If approved, your Unrestricted Permit will be mailed to the address on your Dentist license. You may change the mailing address for your Dentist license and permit(s) online at Update Contact Information.**

6. Phone: _____ _____ Email: _____
   Daytime | Home

INFORMATION ABOUT LOCATION WHERE SEDATION/ANESTHESIA ADMINISTERED

7. Enter the following information about the ***physical location*** of office where sedation/anesthesia will be administered:

   Office Address:_____

   _____ _____ _____
   City | State | Zip

   An Unrestricted Permit is limited to one office location. If you will administer deep sedation or anesthesia at more than one office, submit a separate application for each location.

8. Answer each item to indicate whether the office has each of the following:

Operating theater large enough to adequately accommodate the patient on a table or in an operating chair and to permit an operating team of at least three persons to move freely about the patient?	Yes ☐ No ☐
Operating table or chair that allows the patient to be positioned so the operating team can maintain the airway, quickly alter patient position in an emergency, and provide a firm platform for management of cardiopulmonary resuscitation?	Yes ☐ No ☐
Lighting system that is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system that is battery-powered and of sufficient intensity to safely conclude any procedure underway at the time of general power failure?	Yes ☐ No ☐
Suction equipment that permits aspiration of the oral and pharyngeal cavities and a non-electric backup suction device?	Yes ☐ No ☐
Oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering oxygen to the patient under positive pressure, together with an adequate backup system?	Yes ☐ No ☐
Recovery area (can be the operating theater) that has available oxygen, adequate lighting, suction and electrical outlets where a staff member can observe the patient throughout the recovery period?	Yes ☐ No ☐

9. Answer each item to indicate whether the office has the following ancillary equipment:

Laryngoscope complete with adequate selection of blades and bulb?	Yes ☐ No ☐
Endotracheal tubes and appropriate connectors?	Yes ☐ No ☐
Oral and nasopharyngeal airways?	Yes ☐ No ☐
Tonsillar or pharyngeal-type suction tip adaptable to all office outlets?	Yes ☐ No ☐
Endotracheal tube forcep?	Yes ☐ No ☐
Sphygmomanometer and stethoscope?	Yes ☐ No ☐
Adequate equipment for establishment of an intravenous line?	Yes ☐ No ☐
Precordial stethoscope?	Yes ☐ No ☐
Electrocardioscope and pulse oximetry? Note: This is desirable but not necessary in all instances.	Yes ☐ No ☐

10. Answer each item to indicate whether you know how to treat the following emergencies and whether you have the armamentarium and appropriate drugs to manage these emergencies at this location:

Laryngospasm?	Yes ☐ No ☐	Hypertension?	Yes ☐ No ☐
Syncope?	Yes ☐ No ☐	Cardiac arrest?	Yes ☐ No ☐
Bronchospasm?	Yes ☐ No ☐	Allergic reaction?	Yes ☐ No ☐
Angina pectoris?	Yes ☐ No ☐	Convulsions?	Yes ☐ No ☐
Myocardial infarction?	Yes ☐ No ☐	Emesis and aspiration of foreign materials under anesthesia?	Yes ☐ No ☐
Hypotension?	Yes ☐ No ☐		

11. Answer each item to indicate whether you maintain records in the following manner at this location:

Adequate medical history and physical evaluation records?	Yes ☐ No ☐
Adequate informed consent for surgery and anesthesia?	Yes ☐ No ☐
Adequate anesthesia records which must include *all* of the following: • cardiovascular status (blood pressure and pulse) • respiratory status (respiratory rate or oxygen saturation status) • amount and routes of administered drugs • length of the procedure • any complications of anesthesia?	Yes ☐ No ☐

12. Is the office properly equipped to administer deep sedation, conscious sedation and general anesthesia? Yes ☐ No ☐

13. Is the office properly staffed with a supervised team of auxiliary personnel capable of reasonably handling procedures, problems and emergencies related to deep sedation, conscious sedation and general anesthesia? Yes ☐ No ☐

14. Is the office ready for inspection by the Anesthesia Advisory Committee? Yes ☐ No ☐ **If no, do NOT submit this application until your office is ready for inspection.**

QUALIFICATIONS

15. Select the qualification on which you are basing this permit application.

    ☐ I have two years advanced training in Anesthesiology and related academic subjects (or its equivalent) beyond the undergraduate dental school level in a training program as described in Part II of the Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry. **Submit proof of training.**

    ☐ I am certified as a diplomat of the American Board of Oral and Maxillofacial Surgeons. **Submit proof of your certification.**

    ☐ I have satisfactorily completed a residency in Oral and Maxillofacial Surgery at an institution approved by the ADA Council of Dental Education. **Submit proof of completing your residency.**

    ☐ I am a fellow of the American Dental Society of Anesthesiology. **Submit proof of fellowship.**

    ☐ I am employed by or work with a physician (M.D. or D.O.) who is a member of the anesthesiology staff of an accredited hospital. I understand that the physician must remain on the dental facility's premises until a patient given a general anesthetic or deep sedation regains consciousness. **Arrange for the Board to receive a letter *directly* from the physician stating that you are an employee or co-worker and that he/she is on the anesthesiology staff of a hospital.**

16. Are you currently certified in advanced cardiac life support (ACLS) as documented by the American Heart Association? Yes ☐ No ☐

    Enclose a copy of your current advanced cardiac life support (ACLS) certification card with this application.

DISCLOSURES AND DUTY TO REPORT

17. Have you engaged in the illegal use of controlled dangerous substances within the past two years? Yes ☐ No ☐ If yes, go to Question 18. If no, skip to Question 19.

18. Are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? Yes ☐ No ☐ If yes, explain fully: _____
    _____

19. Have you ever been denied a DEA (Narcotic) registration number? Yes ☐ No ☐ Current DEA #_____
    If yes, submit a letter explaining fully.

20. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or other criminal offense, including any offense for which you have received a pardon, in any jurisdiction? Yes ☐ No ☐ If yes, submit a letter explaining fully, and arrange for the Board office to receive a certified copy of your criminal history record.

21. Have you ever had your professional license subject to disciplinary action (including but not limited to consent agreements, fines, probation, suspension or revocation)? Yes ☐ No ☐ If yes, submit an official Board order or other documents describing the disciplinary action.

22. Has any jurisdiction rejected your application or revoked your professional license? Yes ☐ No ☐ If yes, submit a letter explaining fully. Include copies of all official documents or Board orders.

23. Have you had any malpractice actions brought against you in the past five years? Yes ☐ No ☐ If yes, submit a list of all such actions. Include dates, disposition and amount of awards or settlements, if any.

24. Are any charges or complaints currently pending against you? Yes ☐ No ☐ If yes, submit a letter explaining fully. Include copies of all official documents or Board orders.

25. To obtain a permit in Delaware, you must certify that you understand that you have a **mandatory** obligation to report to the Board within 30 days any mortality or other incident occurring in your dental facility that results in temporary or permanent physical or mental injury requiring hospitalization of a patient during, or as a direct result of, conscious sedation, deep sedation or general anesthesia**.**

    I certify that I have read and understand Section 7.5 of the Rules and Regulations listed above, and that I understand my *duty to report* adverse occurrences. Yes ☐ No ☐

    To assure consideration of your permit application, the Board office must receive all of these items:
    - **Completed, signed and notarized application form**
    - **Fee payment**
    - **All required supporting documentation.**

    Applications that are not complete within six months of filing may be considered abandoned and discarded.

    When your application is complete, please allow 4-6 weeks to receive your license.

AFFIDAVIT

I hereby apply to be considered for a Sedation/Anesthesia Unrestricted Permit by the Board of Dentistry and Dental Hygiene under the standards, qualifications and procedures established under Title 24, Chapter 11, of the *Delaware Code*. I have read the State statute governing the practice of Dentistry and Dental Hygiene in Delaware. I have also received and read the Board's Rules and Regulations regarding anesthesia in Delaware. I understand that the Board may require evidence additional to the material herein.

I hereby swear or affirm that the information contained in this application is correct and I understand that any intentionally fraudulent information will be reported to the Attorney General.

APPLICANT SIGNATURE: _____ Date: _____

County of_____State of _____

Sworn or affirmed before me a Notary Public this_____day of _____, 2_____.

Notary Signature: _____

SEAL

My commission expires on_____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR SUBMITTED WITHOUT THE REQUIRED FEE WILL BE REJECTED.